What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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WHERE THERE IS NO COMMUNITY

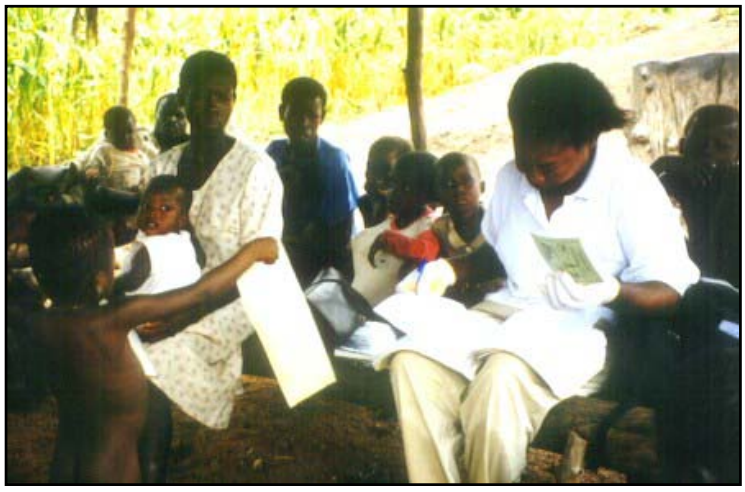
The ideal community is a place where people live in harmony, with activities of common interest organised by benevolent Chiefs, and implemented with enthusiasm by community-spirited volunteers. Unfortunately, such communities don't exist. In fact, in some districts there are communities that are leaderless, plagued by endless conflicts and thereby lacking social cohesion. In such communities, the elegant CHFP community entry procedures for soliciting the cooperation and support of traditional authorities and community members may fail to foster community action. In the case of the CHFP—or what is now referred to as the Navrongo service model—health service planning is directed to community needs and health reorganization begins with community consultation and dialogue. Community leaders are involved in all aspects of primary health care delivery: design, implementation, monitoring, supervision, and evaluation of interventions.

CHC overgrown with weeds—where is the community?

Communities are mobilized to provide residences or construct community health compounds (CHC) where nurses relocate to provide door-to-door health care. Health committees are constituted to supervise the work of community health volunteers who are trained to provide basic curative as well as preventive health services. However, in two communities where Chiefs were not involved from start to finish in the design and execution of programmes, the system was never launched until unconventional action was taken to deal with the absence of community organization.

What Went Wrong?

For the most part the new health delivery approach introduced by the CHFP has been embraced with gusto. But, while some communities put their heads, hearts, and hands into the programme—with the active support of community leaders—others were less enthusiastic, almost apathetic. Is it possible that communities may not be interested in their own affairs, their own health? What should be done in settings where people do not show interest and participation in promoting health service delivery? What is appropriate in settings where there are no communities?



Where there is a community, even little children give the nurse a helping hand

Durbars have been a mainstay of the CHFP design, but in 'nonexisting' communities, such meetings of community members could not be organised. Messages to be delivered to its members regarding the concept of community-based health service delivery never took place. Where communities showed little interest in durbars, support for constructing a CHC was totally lacking. It was reasonable to

assume that community volunteers would not contribute their labour for CHC maintenance, which, in rural Kassena-Nankana, is a yearly necessity.

In one such community, discussions were continually held with the Chief and some elders; yet, when it came to meeting community members at a durbar, problems cropped up, most of the people did not attend. Since it was always a few people who got the health service delivery message, the request for the community to provide or construct a CHC could not take effect and that delayed the posting of the CHO at the initial stages. Several visits were made to the Regent who acted as Chief after the death of the Chief and before the enskinment of a substantive Chief. All efforts to get the Regent to call a durbar were unsuccessful. Flimsy excuses, such as a funeral preventing the people from attending the durbar, took the place of concrete actions. This community was referred to as 'a community in absentia' and the 'uncommunity'.

After several months of fruitless attempts to get the community together, a prominent member of the community visited home from a major southern city. As a well-respected personality in the community—especially by the youth—he was recognized by the CHFP as someone who could catalyze community action. When the individual was contacted he willingly agreed to organise a grand durbar where project staff could address a large gathering. Later he organised youth to mould bricks and with his supervision, the CHC was constructed. The CHFP assisted the community by providing roofing material, cement for the floor, and bitumen for stabilising the walls. Afterwards, an impressive and well-attended durbar was organised to introduce the CHO, YZ, and YN.

Chiefs and elders who had done nothing to foster this action were invited to participate in the durbars, in recognition of their traditional roles of honour. But all present knew the true dynamics of progress. Traditional leaders were motivated by the experience to take the initiative seriously and cooperation with the CHFP improved.

Other communities just sing to their health

What works?

Where there is no sense of community, it takes more than the Chief and his elders to organise people to participate in local initiatives to promote health. The active participation of community members in health service delivery or for that matter, any community-based activity, should not be taken for granted. To successfully deploy nurses to the communities and for them to perform effectively, an influential person may be needed to inspire people and organise them for communal work, especially when it comes to the construction of CHC or their maintenance. Therefore, the Chief should not be the only person to rely on to organise people for communal work. In some communities the Chief is regarded only as a ceremonial head who does not wield sufficient power to organise the people to carry out an activity. It is sometimes necessary to search for an opinion leader to organize community members. Various options are available: school teachers, Assemblymen, social network leaders, women's groups, church groups, and economic networks.

Conclusion

Where traditional leadership is weak or lacking, it is important to convene discussion groups of women and men to guide the programme on feasible means for moving forward with alternative leadership designs. CHO and volunteers remain deployed throughout all experimental areas in Kassena-Nankana to offer services, clearly shows that it is possible to promote health service delivery even in areas where are no communities!

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.